O. If the member only receives ALTCS-covered HCBS that are provided by another funding source (Medicare, Children's Rehabilitative Services, tribal entities), s/he may still be in a HCBS placement and therefore must have a CES completed. The CES should be completed indicating the services received, but with no unit cost paid by the Contractor.

1620-IV PLACEMENT/SERVICE PLANNING STANDARD

REVISION DATES: 02/01/09, 10/01/07, 05/01/06, 01/01/06, 09/01/05, 02/01/05, 10/01/04

INITIAL
EFFECTIVE DATE: 02/14/1996

The case manager is responsible for facilitating placement/services based primarily on the member's choice. Additional input in the decision-making may come from the member's guardian/family/significant other, the case manager's assessment, the Pre-Assessment Screening, the members PCP and/or other service providers.

A guiding principle of the ALTCS program is that members are placed and/or maintained in the most integrated/least restrictive setting. This needs to be the placement goal for ALTCS members as long as cost effectiveness standards can be met in the HCB setting.

A. After the needs assessment is completed, the case manager must discuss the cost effectiveness and availability of needed services with the member and/or member representative.

B. In determining the most appropriate service placement for the member, the case manager and the member and/or the member representative should discuss the following issues:

   1. The member's placement choice

   2. Services necessary to meet the member's needs in the most integrated setting. See Chapter 1200 of this manual for information about the following types of services available:

      a. Home and community based services (HCBS)

      b. Institutional services

      c. Acute care services, and

      d. Behavioral health services.

3. The availability of HCBS in the member's community

4. Cost effectiveness of the member's placement/service choice

5. Covered services which are associated with care in a nursing facility compared to services provided in the member's home or another HCB setting as defined in Chapter 1200

6. The member's Share of Cost (SOC) responsibility. The SOC is the amount of the member's income that s/he must pay towards the cost of long term care services. The amount of the member's SOC is determined and communicated to the member by the local ALTCS Eligibility office.

7. The member's room and board (R & B) responsibility. Since AHCCCS does not cover R & B in a HCB alternative residential setting, this portion of the cost of the care in these settings must be paid by the member or other source (such as the member's family). The monthly R & B amount is determined by and communicated to the member by the ALTCS Contractor.

C. Any member who lives in his/her own home must be allowed to remain in his/her own home as long as HCBS are cost effective. Members cannot be required to enter an alternative residential placement/setting that is "more" cost effective. Refer to Chapter 100 of this Manual for a definition of "own home".

D. Members must be informed that they have the choice to select their spouse to be their paid caregiver for medically necessary and cost effective services (provided the spouse meets all the qualifications as specified in the attendant care section of Policy 1240 of this Manual) not to exceed 40 hours in a 7 day period. The case manager must inform and be available to discuss with member and spouse the financial impact that this choice could have on the eligibility of their household for publicly funded programs, including AHCCCS. The "Spouse Attendant Care Acknowledgement of Understanding" Form (Exhibit 1620-12) must be signed by the member and spouse prior to the authorization of the member's spouse as the paid caregiver. The case manager must be available to assist member/spouse with this decision but is not expected to contact the applicable agencies for the member to determine the impact of the change in the spouse's income on eligibility for programs.

E. Upon the member's or member representative's agreement to the service plan, the case manager is responsible for coordinating the services with appropriate providers.

Placement within an appropriate setting and/or all services to meet the member's needs must be provided as soon as possible. A decision regarding the provision of services requested must be made within 14 calendar days following the receipt of the request/order (3 business days if the member's life, health or ability to attain, maintain or regain maximum function would otherwise be jeopardized). Refer to Title 42 of the Code of Federal Regulations (42 CFR) 438.210 for more information.

Services determined to be medically necessary for a newly enrolled member must be provided to the member within 30 calendar days of the member's enrollment. Services for an existing member must be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

Program Contractors shall develop a standardized system for verifying the delivery of services with the member or representative after authorization.

F. The case manager must ensure that the member or representative understands that some long term care services (such as home health nurse, home health aide or DME) must be ordered by the PCP. These services cannot be provided until the PCP approves them. All orders for medical services must include the frequency, duration and scope of the service(s) required, when applicable.

G. If an ALTCS member does not have a PCP or wishes to change PCP, it is the case manager or designee's responsibility to coordinate the effort to obtain a PCP or to change the PCP.

H. The case manager must also verify that the needed services are available in the member's community. If a service is not currently available, the case manager must substitute a combination of other services in order to meet the member's needs until such time as the desired service becomes available (for example, a combination of personal care or home health aide and homemaker services may substitute for attendant care). A temporary alternative placement may be needed if services cannot be provided to safely meet the member's needs.

I. The case manager is responsible for developing a written service plan (Exhibit 1620-13) that reflects services that will be authorized. It must be noted for each service whether the frequency/quantity of the service has changed since the previous service plan. The member or representative must indicate whether they agree or disagree with each service authorization and sign the service plan at initial development, when there are changes in services and at the time of each service review (every 90 or 180 days). The case manager should provide a copy of the service plan to the member or representative and maintain a copy in the case file.

The case manager is responsible for providing to HCBS in-home members or member representatives the Important Member Rights Notice Form (Exhibit 1620-10), informing them of their rights pursuant to the Ball vs. Biedess order.

J. If the member disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the member with a written notice of action that explains the member's right to file an appeal regarding the placement or service plan determination. Refer to Arizona Administrative Code, Title 9, Chapter 34 (9 A.A.C. 34) for additional information.

K. A written contingency or back-up plan must also be developed for those members who will receive any of the following critical services in their own home:

1. Attendant care, including spouse attendant care
2. Personal care
3. Homemaker, and/or
4. In-home respite.

The term "critical services" is inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.

A gap in critical services is defined as the difference between the number of hours of home care worker critical service scheduled in each member's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the member.

The following situations are not considered gaps:

1. The member is not available to receive the service when the caregiver arrives at the member's home at the scheduled time
2. The member refuses the caregiver when s/he arrives at the member's home, unless the caregiver's ability to accomplish the assigned duties is significantly impaired by the caregiver's condition or state (for example, drug and/or alcohol intoxication)

3. The member refuses services

4. The provider agency or case manager is able to find an alternative caregiver for the scheduled service when the regular caregiver becomes unavailable.

5. The member and regular caregiver agree in advance to reschedule all or part of a scheduled service, and/or

6. The caregiver refuses to go or return to an unsafe or threatening environment at the member's residence.

The contingency plan must include information about actions that the member and/or representative should take to report any gaps and what resources are available to the member, including agency providers and the member's informal support system, to resolve unforeseeable gaps (e.g., regular caregiver illness, resignation without notice, transportation failure, etc.) within two hours. **The informal support system must not be considered the primary source of assistance in the event of a gap, unless this is the member's/family's choice.** An out-of-home placement in a NF or ALF should be the last resort in addressing gaps.

The plan must include the telephone number(s) for the provider and/or contractor that will be responded to promptly 24 hours per day, 7 days per week. The member or member representative should also be provided the Critical Service Gap Report Form (Exhibit 1620-11), which can be mailed to the Contractor as an alternative to calling in the service gap. The member or member representative should be encouraged to call the provider and/or Contractor rather than mailing the Critical Service Gap Report form so that the service gap can be responded to more timely.

In those instances where an unforeseeable gap in critical services occurs, it is the responsibility of the Program Contractor to ensure that critical services are provided within two hours of the report of the gap. However, if the provider agency or case manager is able to contact the member or representative before the scheduled service to advise him/her that the regular caregiver is unavailable, the member or representative may choose an alternative time to receive the service from the regular caregiver and/or an alternate caregiver from the member's informal support system instead of a substitute caregiver from the provider agency's back-up staff. **The member or representative has the final say in how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.**

When the provider and/or Contractor is notified of a gap in services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to

- The reason for the gap, and
- The alternative plan being created to resolve the particular gap and any possible future gaps.

L. The written contingency plan for members receiving those critical services described above must include a Member Service Preference Level from one of the four categories shown below:

1. Needs service within two hours
2. Needs service today
3. Needs service within 48 hours, or
4. Can wait until the next scheduled service date.

Member Service Preference Levels must be developed in cooperation with the member and/or representative and are based on the most critical in-home service that is authorized for the member. The Member Service Preference Level will indicate how quickly the **member chooses** to have a service gap filled if the scheduled caregiver of that critical service is not available. The member or representative must be given the final say about how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.

The case manager should assist the member or representative in determining the member's Service Preference Level by discussing the member's caregiving needs associated with his/her Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs, such as housekeeping, meal preparation and grocery shopping), abilities and cognitive, behavioral and medical status. The case manager should ensure the member or representative has considered all appropriate factors in deciding the member's Service Preference Level, including the availability of the member's informal support system. However, it should not be assumed that the presence of an informal support system will determine the member's Service Preference Level.

The case manager must document the Member Service Preference Level chosen in the case file. This documentation should clearly indicate the member's or representative's involvement in contingency planning.

A member or representative can change the Service Preference Level from a previously determined Service Preference Level at the time of the service gap, depending on the circumstances at the time. The provider agency or Contractor should discuss the current circumstances with the member or representative at the time the gap is reported to determine if there is a change in the Service Preference Level. The plan to resolve the service gap must address the **member's choice** at the time the gap is reported.

The contingency plan must be discussed with the member/representative at least quarterly. A copy of the contingency plan must be given to the member when developed and at the time of each review visit. The member/representative may change the member Service Preference Level and his/her choices for how service gaps will be addressed at any time.

M. Members who reside in a nursing facility should be regularly assessed for HCB discharge potential and allowed or encouraged to change to a HCB service placement, as long as needed services are available and cost effective in the HCB setting.

N. When a member will be admitted to an assisted living center (ALC), the case manager must ensure that the member has the right to exercise his or her choice for single occupancy within that facility. The Single Occupancy Form must be completed and signed by the member or member representative indicating his/her choice. Refer to Exhibit 1620-5 for a copy of this form.

The only exception to this requirement is for an ALC that has been granted an AHCCCS waiver for single occupancy. Refer to the AHCCCS Division of Health Care Management policy "Assisted Living Center Occupancy Exception" for more information.

O. If the member will be admitted to a nursing facility, the case manager must ensure and document that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and Level II evaluation, if indicated, have been completed prior to admission. See Chapter 1200 of this manual for more information.

P. If the member does not intend to pursue receiving HCBS or institutional services, the member needs to be encouraged to withdraw from the ALTCS program voluntarily and seek services through an AHCCCS acute care Contractor or other programs.